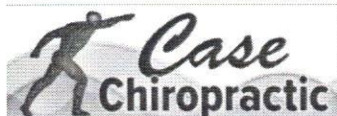
A Fax From:



4010 NW Cache Road ~ Lawton, OK 73505
Phone: 580-357-8688 ~ Fax: 580-357-7483

FAX NUMBER: ________________________ PAGES: (including cover page): ______

DATE: _____________ ATTENTION: _____________________ FROM: _________________________

Request for Medical Records

By signature below I authorize:

________________________________ to release identifiable information from the medical record(s) of: (Patient's Name) __________________________________ to Case Chiropractic, 4010 NW Cache Road, Lawton, OK 73505.

Or, By signature below I authorize:

Case Chiropractic to release identifiable information from the medical record(s) of: (Patient's Name) ___________________________________ to ______________________________________.

Describe protected health information, date, type, or origin:

____

This protected health information is being used or disclosed for the following purposes: The evaluation and diagnosis of my health.

This authorization shall be in force and effect until _________________________.

The information authorized for release may include information which may be considered a communicable or venereal disease, which may include but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus know as acquired immune deficiency syndrome (AIDS).

_____________________________________ ____________________
Signature of Patient or Personal Representative Date

_____________________________________ ____________________
Print Name of Patient or Personal Representative Social Security Number

_____________________________________ ____________________
Description of personal Representative's Authority Patient's Date of Birth

CC: Patient

The information contained in the transmission accompanying this notice is confidential and protected by the physician and patient privilege. It is intended only for the use of the individual or entity identified below. If the render of this message is not the intended recipient, you are hereby notified that any dissemination or distribution of the accompanying communication is prohibited. The parties sending the accompanying documents do not waive the physician and patient privilege. If you have received this communication in error, please notify us immediately by telephone and return the original message to us at the address below via the United States Postal Service.

To: Medicare Patient

To make dealing with Medicare as simple as possible, we have established the following guidelines. Keep in mind that Medicare regulations change frequently and therefore, these guidelines may have to be updated.

We will file all Medicare claims.

We will file all Medicare secondary or supplements insurance.

We are participating providers with Medicare, which means that Medicare pay the clinic directly, however Medicare patients must meet their annual deductible, which we are required to collect at the beginning of services each calendar year. Some supplemental/secondary coverages may pay the Medicare deductible. However, if the patient's supplemental/secondary does not pay the deductible the patient is responsible for their deductible each year.

Medicare pays for 80% of allowed charges. Supplemental/secondary insurance may pay the 20%. If there is no supplemental/secondary insurance, the patient is responsible.

Medicare will not pay for maintenance care and it will be the patient's responsibility..

Medicare does not pay for all of your health care costs. This fact does not mean that you should not receive the uncovered care.

Medicare pays for:
-Manipulation of the spine
-If supported by x-ray and/or examination
-After the deductible is met
-Depending upon the Condition

Medicare does not pay for:
-Examinations
-Physical therapy
-X-rays
-nutritional supplements
-orthopedic supplies
-Maintenance care

If you have questions, please ask, we are here to help you!

I have read and understand the limitations of my Medicare coverage and agree to be personally responsible for the payment of non-covered services if I choose to receive those services.

Case Chiropractic LLC, 4010 NW Cache Road, Lawton, OK 580-357-8688

(B) **Patient Name:** ***(C)*** **Identification Number: (Act#)**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for *(D)* Items listed below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider may have good reason to think you need. We expect Medicare may not pay for the *(D)* Items listed below.

(D) Service Codes	*(E)* Reason Medicare May Not Pay:	*(F)* Estimated Cost:
99202, 99212, 99213, 99214, 99215, 99211	1. Examinations are not covered by Medicare	$50 - $195
72040, 72020, 72110, 72100, 72070	2. X-rays are not covered by Medicare	$45 - $250
97014, 97124, 97035, G0283, 97530	3. Physical therapies are not covered by Medicare	$31 - $60
97110, 97012, 97024, 97012 98943	4. Extremities are not covered by Medicare	$33.75
(extremity Adjustments)	5. In some circumstances Medicare may determine	$27.54- $40.08
Spinal Adjustments 98940, 98941, 98942	Spinal Adjustments are not medically necessary	$55.00
Acupuncture: 97810, 97811, 97813	6. Acupuncture is not covered by Medicare	$80.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.

Choose an option below about whether to receive the *(D)* Items listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

(G) **OPTIONS:** **Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the *(D)* **Items listed** above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the *(D* **Items listed** above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the *(D)* **Items listed** above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

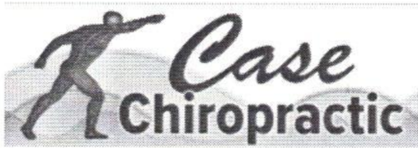
(H) **Additional Information:** In some circumstances Medicare may determine your Spinal Adjustments were not medically necessary and will not allow payment for those services.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature:	*(J)* Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.



4010 NW Cache Road ~ Lawton, OK 73505
Phone: 580-357-8688 ~ Fax: 580-357-7483

Date:________________ Patient#______________

Chiropractic Patient Information

Name: ________________________________ Address (mailing): ______________________________ City: ________________ State: ______ Zip:__________ +(4)_______ Home Phone: ________________________ Cell ____________________________

E-mail address:____

Race (circle only 1) : American Indian Alaskan Native Asian White Black or African American Native Hawaiian Other Pacific Islander Declined to State

Ethnicity (circle only 1) Hispanic or Latino Not Hispanic or Latino Declined to State **Preferred Language:** __________

Marital: M S W D Age: _____ Birth Date: ________________ Social Security #______________________

How were you referred to our office?____

Occupation: __________________ Employer: ________________________ Employer's Address: ______________________

Work Phone: ____________________________

Spouse:__________________ Occupation:_____________ Employer:______________________________

HISTORY OF PRESENT ILLNESS: List in order of severity if more than one:

Chief Complaint: (Purpose of this appointment): ____

Date symptoms appeared or accident happened: ____

Is this due to: □Auto □Work □Other: ___________________________________ Days lost from work: _________

Have you ever had the same or a similar condition? □ Yes □ No If yes, when: ______________________

Treatment already received: □ Medication □ Physical Therapy □ Surgery □ Chiropractic □ None □ Other

Rate your pain on a scale of 1 to 10. ____

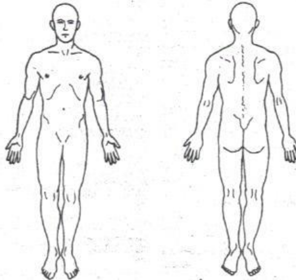
Does this pain affect you : constantly______ intermittently_________Occasionally_______________

Name and address of Doctor(s) who have treated you: ____

Date of last: Physical examination: _________ Spinal Exam: ________ Spinal X Rays: ________ Chest X Rays: ________
MRI________ CT_______ Bone Density ______Bone Scan _________ Blood Test: ________ Urine Test: ____________

Please Indicate Region of Complaint

- □ HEADACHE PAIN
- □ NECK PAIN
- □ LOW BACK PAIN
- □ SHOULDER PAIN
- □ ELBOW PAIN
- □ WRIST PAIN
- □ HAND PAIN
- □ HIP PAIN
- □ KNEE PAIN
- □ ANKLE PAIN
- □ FOOT PAIN
- □ TMJ
- □ UPPER/MID BACK PAIN
- □ OTHER ____________________



Use the letters listed below to indicate the *type* and *location* of your pain and sensations...

KEY

A = ACHE B = B BURNING
S = STABBING N = NUMBNESS
P = PINS & NEEDLES
O = OTHER

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check all conditions that apply to you)

□ Broken or Fractured Bones	□ Osteoarthritis	□ Eating Disorder	□ Heart Disease	□ Prosthesis
□ Circulatory Problems	□ Osteoporosis	□ Alcoholism	□ COPD	□ Psychiatric Care
□ Rheumatoid Arthritis	□ Pace Maker	□ Drug Addiction	□ Migraines	□ Thyroid
□ Seizures/Convulsions	□ Diabetes	□ HIV Positive	□ Vaginal Infections	□ STD
□ A Congenital Disease	□ Cancer	□ Gall Bladder	□ Ulcer	□ Kidney disease
□ Excessive Bleeding	□ Ruptures	□ Depression	□ Prostate	□ Reflux
□ High □ Low Blood Pressure	□ Coughing Blood	□ Epilepsy	□ Liver Disease	□ Other________

Do you have a history of stroke or hypertension?____

Smoking Status: Start Date: _________End Date:__________ Currently (circle): Every Day / Some Days / Quit / Never

In an effort to quit smoking, I am currently taking; __________________

Patient's Initials ________________

Date:________________ Patient Name:________________________________ Patient #________________

Are you currently taking any medications, including over the counter? Yes No If Yes, please indicate the following:

Medication: ____________mg_____
Route: (circle 1) Oral Tab/Capsule Intravenous Other: ___________
Frequency: ____________
Began Use: ____________
Discontinued Use: ____________

Medication: ____________mg_____
Route: (circle 1) Oral Tab / Capsule Intravenous Other: ___________
Frequency: ____________
Began Use: ____________
Discontinued Use: ____________

Medication: ____________mg_____
Route: (circle 1) Oral Tab / Capsule Intravenous Other ___________
Frequency: ____________
Began Use: ____________
Discontinued Use:____________

If there are more than three medications we can call your pharmacy for your list or bring all bottles on next visit.

Do you have any allergies to medication? Yes No If Yes, please indicate the following:

MEDICATION ALLERGIES	SEASONAL ALLERGIES	VITAMINS/HERBS/MINERALS	
EXERCISE	**WORK/HOME ACTIVITY**	**HABITS**	**HOBBIES**
☐ None ☐ Moderate ☐ Daily ☐ Heavy	☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor	☐ Alcohol: Drinks/Day ____ ☐ Caffeine: Drinks/Day ____ ☐ High Stress Level: Reason?	

SURGERIES/INJURIES	**Description:**	**Date**
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Please list any other health problems you have, no matter how insignificant they may be:

What percentage of time during the day (at home / your job / away from home) do you spend:
Lifting: ________ Pulling ________ Pushing ______ Sitting: ________ Bending: _________ Working at a computer: ___________

FAMILY HISTORY: Parents: (check one)

Father: ☐ living ☐ deceased ☐ Current age if still living: _______ Cause of death and age at death if deceased: _______

Mother: ☐ living ☐ deceased ☐ Current age if still living: _______ Cause of death and age at death if deceased: _______

Do you have any family members who suffer from the same condition you do? ☐ Yes ☐ No If so, please list:

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

_______ Tuberculosis _______ Cancer _______ Mental Illness _______ Kidney Disease
_______ Diabetes _______ Asthma _______ Heart Disease _______ Liver Disease
_______ Stroke _______ Arthritis _______ Lung Disease _______ Other

Please check any and all insurance coverage applicable in this case: ☐ Major Medical ☐ Medicare ☐ Medigap/supplemental ☐ Medicare secondary insurance ☐ Auto Accident ☐ Worker's Comp ☐ Medical Savings Acct & Flex Plans ☐ Other

Name of Primary Insurance Company ________________________________

Name of Secondary Insurance Company (if any):________________________________

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Case Chiropractic. I understand and agree to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I authorize Case Chiropractic to communicate with my primary care physician and to use my name on a referral board when I refer.

We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

☐ **Check this box of you would like to have access to your Electronic Health Records**

Patient's Signature ________________________________ Date ____________

Guardian's Signature Authorizing Care ________________________________ Date ____________

Doctor's Signature ________________________________ Date ____________

Conran
Review of Systems

Patient Name: ____________________ Today's Date: ____________________

Please check the signs and/or symptoms related to the following body systems you now have or have experienced in the past.

CONSTITUTIONAL
- ☐ Deny All
- ☐ Chills
- ☐ Drowsiness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

EYES
- ☐ Deny All
- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Change in Vision
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Eye Pain
- ☐ Field Cuts
- ☐ Glaucoma
- ☐ Sensitivity to Light
- ☐ Tearing
- ☐ Wears Glasses

CARDIOVASCULAR
- ☐ Deny All
- ☐ Angina
- ☐ Chest Pain
- ☐ Claudication
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Orthopnea
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Swelling of Legs
- ☐ Varicose Veins

RESPIRATORY
- ☐ Deny All
- ☐ Asthma
- ☐ Bronchitis
- ☐ Dry Cough
- ☐ Productive Cough
- ☐ Coughing up Blood
- ☐ Difficulty Breathing
- ☐ Difficulty Sleeping
- ☐ Hemoptysis
- ☐ Pneumonia
- ☐ Sputum Production
- ☐ Wheezing

MUSCULOSKELETAL
- ☐ Deny All
- ☐ Arthritis
- ☐ Neck Pain
- ☐ Decreased Motion
- ☐ Gout
- ☐ Injuries
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Locking Joints
- ☐ Back Pain
- ☐ Muscle Cramps
- ☐ Muscle Pain
- ☐ Muscle Twitching
- ☐ Muscle Weakness
- ☐ Swelling

INTEGUMENTARY
- ☐ Deny All
- ☐ Breast Lumps / Pain
- ☐ Change in Nail Texture
- ☐ Change in Skin Color
- ☐ Eczema
- ☐ Hair Growth
- ☐ Hair Loss
- ☐ History of Skin Disorders
- ☐ Hives
- ☐ Itching
- ☐ Paresthesia
- ☐ Rash
- ☐ Skin Lesions

GASTROINTESTINAL
- ☐ Deny All
- ☐ Abdominal Pain
- ☐ Belching
- ☐ Black, Tarry Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Jaundice
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Abnormal Stool Caliber
- ☐ Abnormal Stool Color
- ☐ Abnormal Stool Consistency
- ☐ Vomiting
- ☐ Vomiting Blood

GENITOURINARY
- ☐ Deny All
- ☐ Birth Control Therapy
- ☐ Burning Urination
- ☐ Cramps
- ☐ Erectile Dysfunction
- ☐ Frequent Urination
- ☐ Hesitancy / Dribbling
- ☐ Hormone Therapy
- ☐ Irregular Menstruation
- ☐ Lack of Bladder Control
- ☐ Prostate Problems
- ☐ Urine Retention
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge

ENMT
- ☐ Deny All
- ☐ Bad Breath
- ☐ Dentures
- ☐ Deviated Septum
- ☐ Difficulty Swallowing
- ☐ Discharge
- ☐ Dry Mouth
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Frequent Sore Throats
- ☐ Head Injury
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Infections
- ☐ Runny Nose
- ☐ Snoring
- ☐ Sore Throat
- ☐ Ringing in Ears
- ☐ TMJ Problems
- ☐ Ulcers

NEUROLOGICAL
- ☐ Deny All
- ☐ Change in Concentration
- ☐ Change in Memory
- ☐ Dizziness
- ☐ Headache
- ☐ Imbalance
- ☐ Loss of Consciousness
- ☐ Loss of Memory
- ☐ Numbness
- ☐ Seizures
- ☐ Sleep Disturbance
- ☐ Slurred Speech
- ☐ Stress
- ☐ Strokes
- ☐ Tremors

PSYCHIATRIC
- ☐ Deny All
- ☐ Agitation
- ☐ Anxiety
- ☐ Appetite Changes
- ☐ Behavioral Changes
- ☐ Bipolar Disorder
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Homicidal Indication
- ☐ Insomnia
- ☐ Location Disorientation
- ☐ Memory Loss
- ☐ Substance Abuse
- ☐ Suicidal Indication
- ☐ Time Disorientation

ENDOCRINE
- ☐ Deny All
- ☐ Cold Intolerance
- ☐ Diabetes
- ☐ Excessive Appetite
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Goiter
- ☐ Hair Loss
- ☐ Heat Intolerance
- ☐ Unusual Hair Growth
- ☐ Voice Changes

HEMATOLOGIC / LYMPHATIC
- ☐ Deny All
- ☐ Anemia
- ☐ Bleeding
- ☐ Blood Clotting
- ☐ Blood Transfusions
- ☐ Bruise Easily
- ☐ Lymph Node Swelling

ALLERGIC / IMMUNOLOGIC
- ☐ Deny All
- ☐ History of Anaphylaxis
- ☐ Itchy Eyes
- ☐ Sneezing
- ☐ Specific Food Intolerance

Signature: ______________________________ Date: ____________________

4010 NW Cache Road ~ Lawton, OK 73505
Phone: 580-357-8688 ~ Fax: 580-357-7483

Neck Disability Index

Date: ________________ Patient Name: ______________________________ Patient # __________

Please read instructions;

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1-PAIN INTENSITY

A. I have no pain at the moment.
B. The pain is very mild at the moment.
C. The pain is moderate at the moment.
D. The pain is fairly severe at the moment.
E. The pain is very severe at the moment.
F. The pain is the worst imaginable at the moment.

SECTION 2-PERSONAL CARE (Washing Dressing, etc)

A. I can look after myself normally, without causing extra pain.
B. I can look after myself normally, but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self care.
F. I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3-LIFTING

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it gives extra pain.
C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4-READING

A. I can read as much as I want to, with no pain in my neck.
B. I can read as much as I want to, with slight pain in my neck.
C. I can read as much as I want to, with moderate pain in my neck.
D. I can't read as much as I want, because of moderate pain in my neck.
E. I can hardly read at all, because of severe pain in my neck.
F. I cannot read at all.

SECTION 5-HEADACHES

A. I have no headaches at all.
B. I have slight headaches that come infrequently.
C. I have moderate headaches that come infrequently.
D. I have moderate headaches that come frequently.
E. I have severe headaches that come frequently.
F. I have headaches almost all the time.

SECTION 6-CONCENTRATION

A. I can concentrate fully when I want to, with no difficulty.
B. I can concentrate fully when I want to, with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7-WORK

A. I can as much work as I want to.
B. I can do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8- DRIVING

A. I can drive my car without any neck pain.
B. I can drive my car as long as I want, with slight pain in my neck.
C. I can drive my car as long as I want, with moderate pain in my neck.
D. I can't drive my car as long as I want, because of moderate pain in my neck.
E. I can hardly drive at all, because of severe pain in my neck.
F. I can't drive my car at all.

SECTION 9-SLEEPING

A. I have no trouble sleeping.
B. My sleep is slightly disturbed (less than 1 hr sleepless)
C. My sleep is mildly disturbed (1-2 hrs sleepless).
D. My sleep is moderately disturbed (2-3 hrs sleepless).
E. My sleep is greatly disturbed (3-5 hrs sleepless).
F. My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10-RECREATION

A. I am able to engage in all my recreation activities, with no neck pain at all.
B. I am able to engage in all my recreation activities, with some neck pain.
C. I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
D. I am able to engage in a few of my recreation activities, because of pain in my neck
E. I can hardly do any recreation activities, because of pain in my neck.
F. I can't do any recreation activities at all.

Patients Signature ______________________________ Date __________

Instructions:

1. The NDI is scored in the same way as the Oswestry Disability Index.
2. Using this system, a score of 10-25% (i.e., 5-14 points) is considered by the authors to constitute mild disability; 30-40% is moderate; 50-68% is severe; 72% or more is complex.

Case Chiropractic

Name: ____________________

4010 NW Cache Road, Lawton, OK 73505

Date:____________________
Patient #:________________

Please Read: This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **Please, just, circle the one choice which best describes your problem right now.**

Section 1—Pain Intensity
A. The pain comes and goes and is very mild.

Section 1—Pain Intensity
A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate
D. The pain is moderate and does not vary much.
E. The pain comes and goes and is severe.
F. The pain is severe and does not vary much.

Section 2—Personal Care
A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do some washing and dressing without help.
F. Because of the pain, I am unable to do any washing and dressing without help.

Section 3—Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table
E. Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

Section 4—Walking
A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than one mile.
C. Pain prevents me from walking more than 1/2 mile.
D. Pain prevents me from walking more than 1/4 mile.
E. I can only walk while using a cane or on crutches.
F. I am in bed most of the time and have to crawl to the toilet.

Section 5—Sitting
A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than ½ hour.
E. Pain prevents me from sitting more than ten minutes.
F. Pain prevents me from sitting at all.

Patient signature______________________________

Section 6—Standing
A. I can stand as long as I want without pain.

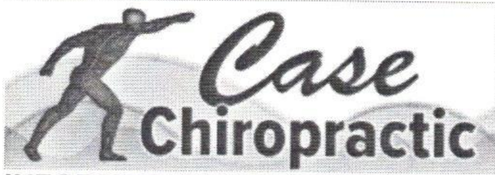
Section 6—Standing
A. I can stand as long as I want without pain.
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I can't stand for more than 10 minutes without increasing pain.
F. I avoid standing because it immediately increases the pain.

Section 7—Sleeping
A. I get no pain in bed.
B. I get some pain in bed, but it does not prevent me from sleeping well.
C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

Section 8—Social Life
A. My social life is normal and gives me no pain.
B. My social life is normal, but increases my degree of pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interactions, e.g. dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. I have hardly any social life because of the pain.

Section 9—Traveling
A. I get no pain while traveling.
B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain prevents all forms of travel except that done lying down.

Section 10—Changing Degree of Pain
A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.



4010 NW Cache Road ~ Lawton, OK 73505
Phone: 580-357-8688 ~ Fax: 580-357-7483

INFORMED CONSENT FOR TREATMENT

PATIENT NAME ___________________________________

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/ Examination/ Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

__spinal manipulation therapy	__palpation	__vital signs
__range of motion testing	__orthopedic testing	__basic neurological testing
__muscle strength testing	__postural analysis	__EMS
__radiographic studies	__hot-cold therapy	__other (please explain)

____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest,
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers,
- Hospitalization,
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the information of adhesions and reduce mobility when may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

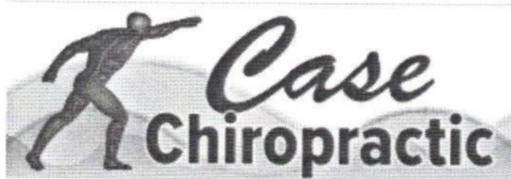
DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Casey A. Conran and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date: ___________ **Patient's Name** ____________________________ **Patient's signature** __________________________

Date: ___________ **Signature of Parent or Guardian (if a minor)** ___________________________________

Date: ___________ **Doctor's Name:** Casey Conran D.C. **Doctor's Signature:** ________________________



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Financial Policy

The following information is provided to avoid any misunderstanding or disagreement concerning Case Chiropractic's patient financial policy.

Prompt payment, allows us to control costs. Outstanding accounts cost both of us time and money: therefore, all patients will be required to establish financial arrangements for payment of their accounts.

Worker's compensation patients As long as your care is determined to be W/C there is no financial responsibility due from you. However, if your claim is controverted or denied the balance will be your responsibility and the financial policy will apply to your account.

It should be mentioned that your insurance coverage is an agreement between you and your insurer. As a courtesy our practice will bill your insurance carrier. After 90 days It will then be your responsibility to remit payment for any unpaid claims by your carrier as well as any and all charges not covered by your carrier.

All copays, deductibles, and patient co-insurances are due at the time of service.

Our office does accept third party liability, however, if the third party insurance does not pay it is the patient's responsibility.

If your carrier requires Authorization our office will be happy to assist you in this process however, ultimately this is your responsibility.

Each month you will receive a monthly statement for services which are due and payable within 10 days.

All patients refusing to remit payment after the 10 days have passed; will force us to limit their future credit until the previous balance is paid in full. All patients will be required to sign a written legal agreement with our practice. All accounts are subject to be forwarded to a collection agency and credit bureau as well as all additional costs occurred in collecting the debt.

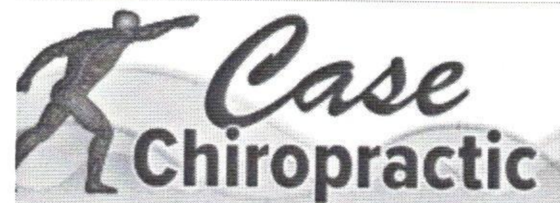
All returned check for non-sufficient funds will be subjected to a $40.00 fee.

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and open communication. Our staff has been instructed to make every effort available to you to clarify any misunderstandings you have concerning your balance. We hope to possibly avoid any disagreement over payment for professional services.

If you have any questions concerning our policy or need assistance, please contact us immediately.

______________________________ ________________________
Patient's Name Date

______________________________ ________________________
Guardian Signature Date



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Name of Patient ______________________________ Date ____________

WHAT TO EXPECT AFTER YOUR FIRST ADJUSTMENT

Please read the following information carefully. Sign the bottom of the sheet to indicate that you understand the instructions and information given.

1. If you have never been adjusted, or if it has been awhile since your last adjustment, you may experience soreness or discomfort for a few hours to a few days. This is a normal reaction to chiropractic adjustments.

2. If you are sore, use ice packs on the affected area. Ice therapy consists of the use of ice packs at 20-minute intervals followed by 40 minutes of rest. This can be repeated as often as needed. Do not apply ice directly to bare skin. Always protect skin with a thin covering such as a shirt or light towel. Cover the ice pack with a thick towel to retain the cold.

3. Do not use heat except under the doctor's instruction. Heat may aggravate your injury.

4. Stay away from heavy lifting or repetitive movements until the doctor indicates you are ready for normal activities. Strenuous athletic activities such as running, lifting weights, impact aerobics, racquetball, tennis, skiing, bowling, etc. should be avoided. Other things to avoid are yard work such as raking, digging, lifting heavy objects such as groceries, pets and children, and any other activities that could aggravate or re-injure your condition.

5. Unless indicated by the doctor, you may return to work/school after your appointment.

6. If you experience pain between scheduled visits, contact the clinic at 357-8688 during office hours.

I have read and understand the instructions given for my follow-up care.

______________________________ ____________
Patient's Signature Date

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Phone: (580)357-8688 Fax: (580)357-7483
WWW.CaseChiro.com

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

____

Name of Patient Date